MAIN MEMBER INFORMATION:

* ID NUMBER: * SURNAME:
* FULL NAMES:
INITIALS: GENDER: M F TITLE: * DATE OF BIRTH: C C Y Y M M D D
HOME LANGUAGE:
* CELL NUMBER: HOME NUMBER:
WORK NUMBER: EMPLOYER:
FAX NUMBER:
E-MAIL ADDRESS: E-MAIL STATEMENT? Y N
* POSTAL ADDRESS:
* POSTAL CODE:
PHYSICAL ADDRESS:
POSTAL CODE:

* MEDICAL SCHEME:
* PLAN/OPTION: GAP cover: Y N
* MEMBER NO.: MAIN MEMBER DEP CODE:

PATIENT INFORMATION:

* ID NUMBER: * SURNAME:
* FULL NAMES: NICK NAME:
INITIALS: GENDER: M F TITLE: * DATE OF BIRTH: C C Y Y M M D D
HOME LANGUAGE:
CELL NUMBER: Use this number for appointments / test results Y N
Main member's Cell Phone number will be used if the above is ***No***
HOME NUMBER: WORK NUMBER:
E-MAIL ADDRESS:
OCCUPATION: MARITAL STATUS:
RELATIONSHIP TO MAIN MEMBER: * PATIENT DEP CODE:
AGE: years HEIGHT: , m WEIGHT: kg
REFERRING DR: TEL:

NEXT OF KIN: (*Not from the same physical address*)

INITIALS: TITLE: SURNAME:
FULL NAMES:
CELL NUMBER: RELATIONSHIP TO PATIENT:

Hereby I confirm that the information I supplied is true and I am responsible for any false information provided.

* NAME IN PRINT:
* DATE OF SIGNATURE: C C Y Y M M D D * SIGNATURE:

Allow mass communication or notices from practice Y N

All fields with * are mandatory. Please note that you (or your parent/guardian) remain liable for the account for services rendered by this practice, even if you are insured by a medical aid or other third party. Please ensure that you have read and signed the attached Doctor-Patient contract.